Aged Care Emergency model evaluation

Hospital and Local Health District:

1. **Overview of the implementation of Aged Care Emergency (ACE) program**

Please provide a concise overview of why you applied for funding to implement the ACE model. How did you assess the need for implementation of the ACE model?

The Richmond area is serviced by Lismore Base Hospital (LBH) and its surrounding network of hospitals. Australian Bureau of Statistics data projects that in 2016, 13% of the population of Richmond will be aged over 70 years (compared to 11% for the broader NSW population).

In the 12 months to March 2012 there were 5,382 presentations to LBH Emergency Department (ED) by patients aged 70 years and over. This represented 18% of all 29,441 ED presentations. The admission rate for patients aged 70 years and over who present to LBH ED was 68% compared with an admission rate of 29% for those patients less than 70 years.

Patients from RACFs are typically difficult to 'flow' through the hospital (e.g. due to constraints to transportation home, and the reduced availability of RACF nurses on evening and weekend shifts), resulting in extended hospital stays. Therefore managing RACF patients so that they do not need to present to ED should benefit not only the patients and the ED, but LBH as a whole.

It was not possible to accurately determine the specific number of RACF presentations to LBH ED as the information systems did not collect this data in a way that is easily extracted. Based upon the local population and anecdotal feedback from ED and ASET staff, RACF presentations are believed to be significant in number. LBH ED management believed that approximately 25% of RACF presentations to ED should be possible to be avoided through appropriate acute care assessment and management at the RACF. Based upon the 17% reduction achieved at HNELHD and the fact that not all RACFs can initially be included within ACE, LBH ED set a target for reduction in RACF presentations of 20% within 24 months.

2. **Objectives of the implementation of ACE**

Please state the objectives you set out to achieve with implementation of the ACE model, was there any change to this during the project?

The objectives that we set out to achieve were:

1. To reduce avoidable Emergency Department presentations

2. To reduce the length of stay in the Emergency Department

3. To reduce avoidable acute hospital admissions and occupied bed days

4. To improve the patient journey

5. To build clinical capacity in the RACF through regular education and improved linkages to existing services.

All of the above objectives were met and will be discussed in more detail in question 3. There was no change to this during the term of the project.

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3. Scope of the implementation and ACE model used

What were the specifics of the ACE model you implemented in your Hospital? In what ways did you deviate from the documented NSW ACE model and why? How did you determine the elements of the model that would suit your Hospital's purposes?

The specifics of the ACE Model introduced at LBH are:

- Telephone consultation process
- Evidence based algorithms
- Support and education to the staff from RACFs to help them feel confident in looking after this cohort of patients and avoid transfer of patients to hospital –onsite at the RACF and simulator training
- Establishing goals of care prior to arrival in ED
- Proactive case management in ED to enhance the flow and coordination of care of patients transferred to ED- improved communication, goals of care
- Collaborate working relationships with GPs, community and hospital care providers and Medicare Local
- Coordinate hospital acute care services ,NSWAS,RACFs to ensure Goals of care are met
- Support families to have their wishes in regards to ACD respected and communicated through all parts of the patient journey.
- Collaboration of relationships with all relevant stakeholders through maintaining regular communication

The ACE model used at LBH closely followed the NSW ACE model however they did not have access to the Extended Care Paramedics in the local ambulance service that were used at John Hunter Hospital. Before implementation of the Project, ACE met with the NSWAS and discussed the project and their role in it. The Ambulance Service was very supportive and keen to implement strategies such as 'hot transfers' (being able to offload a patient and take a resident home to free up an ED bed) which helped when ED was in bed block. Unfortunately, due to restrictions with the Paramedics scope of practice, they were unable to provide skills such as suturing and gluing of appropriate wounds, therefore patients requiring this service needed to be transferred to the ED.

When the proposal for funding was made it was thought Lismore Base Hospital and its patients would benefit from all of the outcomes that are associated with the model and therefore the intention was to replicate as many elements of the model as possible in order to leverage from the experience at John Hunter Hospital.

In particular LBH wanted to provide targeted training for the staff in the RACFs particularly RNs within in the acute setting of LBH, extend the service to provide outreach in cases where RACF staff would require hands on support to prevent a presentation and develop care pathways for ED care in order to reduce the ED LOS for those patients who did present to ED.

When commenced, the ACE Project discussed the possibility of bringing RACF staff onsite to Lismore Base to provide education in skills such as cannulation, administration of IVI antibiotics and PICC line management and dressings. After further communication with the managers and staff from the RACFs, it appeared that we needed to start first with basic assessments and handovers. Presentations were developed related to algorithms from the ACE manual to present to RACF onsite suitable for all levels of staff.

During the planning stage of the Project, we approached the community services to discuss how they could be involved to improve the linkage to existing services such as Stomal and Continence therapy, Diabetic Educator (community based as nil at LBH), Palliative care, and Hospital in the Home (HITH) community nurses. It was well received but there were restrictions that prevented them from visiting the RACFs; Palliative Care was only able to visit or give advice to the RACFs if the resident had been referred by the GP and was familiar to the team. The

Stomal and Continence CNC was happy to give advice over the phone but was unable to visit the RACFs due to funding restrictions but could do outpatient consults in LBH rooms, HITH could only attend if they were to provide a service not able to be supplied by the RACF RNs, after the patient had attended ED and had been admitted under the ED Physician.

4. Methodology used in the implementation

This section should evaluate the success or otherwise of the methodology used to implement the model of care. What were the barriers and enablers to project success or otherwise? What was your communication strategy and how effective was it? What recommendations would you offer other Hospitals about to commence implementation of ACE?

Success in the implementation of the ACE Program is shown in the data collected and analysed by Greg Fairbrother

- The group of 13 patients who presented to us within our hours of operation, and who went on to be returned to the RACF had a mean **ED LOS of 3.3 hours** (SD 2.9). The combined remainder of the 2013 group had a mean ED LOS of 10.8 hours (SD 5.6). This difference was significant (ANOVA: F=10.2; P=0.002).

- *The average **ED LOS 6.7 hour**s applied for all ACE patients who presented to ED and were returned to the RACF*

- *An average of **1.5 occupied bed days were saved per patient** during the 5 month period*

Barriers to the project success included:

-RACFs were regularly busy with issues such as accreditation and mandatory training in their facility that prevented ACE being able to access staff. This also effected communication as emails and phone calls were not returned in a timely fashion when staff were busy.

-The Emergency Department was often bed blocked which restricted the flow of patients.

-The closure of one of the RACFs included in the project. This resulted in staff and residents moving to other facilities in the area, one of which joined the project who found the intake very stressful and consequently decreased the interaction with ACE (unable to give education and less communication) as they were so busy.

- Lismore Base Hospital's Director of Nursing who was the Executive Sponsor, changed three times during the project. Although all were supportive, it affected the project as there was a lack of continuity.

- Being able to monitor if facilities were using the manuals.

- At some facilities, the ACE manual conflicted with the facilities protocols. For example, one of the facilities included in the ACE Project would not allow Certificate 3 and 4 staff to administer IMI Glucagon. ACE offered education for this (as people with diabetes families are able to administer IM Glucagon in the community), but it was refused as there facility had a 'no injection policy'. Another example was the ACE manual prompting staff to administer three doses of GTN when a resident was experiencing chest pain, however the facility policy only allowed staff to administer two doses.

- Time limitations to build relationships and trust amongst some GPs, RACFs, hospital staff and all involved is a barrier as it takes time for people to see your words put into action. As the project progresses ACE is receiving an

increased number of enquiries from ward staff regarding discharge planning as they become increasingly aware of the project and its contact with RACFs.

Enablers to project success included:

From the beginning of the project, ACE had support from all of the people directly involved:

-The RACFs ACE approached were all keen to be included, and all levels of staff showed interest and enthusiasm in regards to the project.

-Anticipated resistance from GPs did not happen as a large proportion of the GPs that cared for residents in the RACFs were happy to be contacted and were supportive of the ACE CNC role and open to suggestions made by ACE.

-The support of Medicare Local played a big part in the project's success. Medicare Local worked alongside ACE with the common interest of gathering information on what the RACFs stated they would most like education on, and provided complimentary education on things such as dementia and palliative care while ACE focused on more clinical skills and the manual. Medicare Local asked if there was any equipment needed by RACF staff that would assist staff to use the ACE model of care, and consequently purchased vital signs machines for the RACFs involved. Medicare Local also funded a dinner to introduce the local GPs to ACE, and the Simulator Education days that were offered to RACF staff.

-LBH Emergency Department nursing and medical staff supported the ACE CNCs, and assisted with problem solving for the benefit of the patient.

-The NSW Ambulance Service supported ACE by occasionally providing 'hot transfers' where they offloaded their patient on the stretcher and then took a resident awaiting transport back to the RACF, which improved bed block. The NSWAS also assisted in commencing treatment such as taking the patients for X-Rays whilst waiting on the ambulance stretcher. On some occasions, they would wait for a resident to have an investigation and assessment of a less acute injury or requiring a straight forward procedure, and take the resident back to their facility if they did not have a fracture or require admission preventing an overnight or extended LOS in ED.

-The ACE Steering Committee provided support to help guide and spread the ACE project throughout LBH in a positive direction.

- Lismore Base Hospital's medical staff including the Geriatricians and their teams, the Emergency Department Consultants and General Medicine Physicians were very supportive of the project and assisted with the implementation.

- It can be difficult to arrange transfer back to the RACF after hours due to transport and RACF policy restrictions. ACE organised an agreement with the LBH Physicians to admit patients overnight to the ward from RACFs if their treatment was complete, only waiting for transport home and if they had a discharge letter completed. This allowed a bed to become available in the ED, gave the patient a calmer environment to sleep in and hospital transport or ambulance were to be booked first thing in the morning.

-The Nursing Supervisors and Bed Manager all supported and worked with ACE for the benefit of the residents.

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Communication strategy and effectiveness:

ACE implemented many communication strategies which included:

-Making face to face contact initially with stakeholders.

-When visiting the RACFs for the first time, ACE had the Acting Medical Director of the ED accompany them to explain the need and benefits of introducing the project.

-During the planning stage of the project, ACE contacted all the stakeholders and asked them their preferred method of communication (e.g.; email, phone, face to face) and adhered to it.

-Sent out regular emails to stakeholders to provide ongoing communication.

-When emails were sent regarding important meetings or appointments, ACE followed the emails up with a phone call.

-ACE ensured that discharge summaries were sent to the GPs and the RACFs when residents went home from the Emergency Department. On the occasions when they were not completed by the ED Medical officer, ACE would complete them to guarantee that the GPs and RACFs were kept informed regarding their patients ED visit.

-Developed relationships with Nurse Educators at the RACFs and worked with them to educate their staff.

-Held regular Steering Committee meetings.

-Organised Stakeholder meetings.

-Wrote newsletters that included an update on what was happening with the project, provided examples of positive experiences for 'ACE patients', some useful facts, and information regarding things happening in the future.

-Distributed the newsletters and any important information to hospital employees such as the Nurse Managers, Bed Manager, ED medical and nursing staff, AARCs, ASET, Pharmacy, the NSWAS, Hospital transport, HITH, and LBH ward NUMs as well as the GPs and RACFs involved.

-Distributed brochures and flyers to GPs, families of residents in RACFs, NSWAS, and hospital and RACF staff.

-Held in services for ED and LBH ward staff regarding the project and increase awareness on what happens at RACFs, to give them a better understanding of how they differ and bridge the gap between the RACFs and hospital. It also gives them a better understanding of why they need to communicate with each facility and organise discharge planning in advance as each facility is different. For example: fax the medication chart if there are any changes in medication to the RACF to give the facility time to organise a webster pack suitable for the staff in RACF to administer as many do not have RNs on duty after hours.

-During the implementation phase of the project, ACE addressed the issue of how the GPs wanted to be contacted by ACE regarding patients in ED or at the RACF that they were involved with. We were conscious of the fact that they were often seeing patients in their GP Practices at the time of the phone call, and asked if they wanted to be interrupted or if they preferred to call us back between patients.

We found that by addressing peoples preferred method of communication we were able to contact them easier, were more likely to get a response and helped improve and maintain working relationships.

Including groups such as Nurse Supervisors, NSWAS, and ward Nurse Unit Managers when we sent out our newsletters and important emails, allowed us to communicate and keep the people that we had less interaction with informed.

Recommendations to other hospitals starting the ACE project:

-Try and build good relationships with all key stakeholders from the beginning and work together with the RACFs to evaluate what education they would like and need, and provide them with the same, once education starts and patients begin presenting, communication improves, relationships build and it becomes more obvious what areas you need to focus on. Be prepared to give education to only small groups of 2-4 staff at times, as RACFs can have busy days and will be unable to get many off the floor.

-Return calls and emails promptly to keep momentum going, and provide good communication keeping everyone in the loop.

-Try and break down barriers and misconceptions that hospitals and RACFs have about each other. Keep both parties informed regarding the differences between each, and provide insight into why things may happen that they are not familiar with.

5. Measures of success of the implementation of ACE

Please include data as follows pre and post implementation of ACE (as indicated in the NSW ACE Model of Care document)

- *Review of health outcomes related data*
- *ED Length of Stay data*
- *Hospital LOS*
- *Bed days utilised by patients from RACFs*
- *Number of ED presentations from RACFs*
- *Rates of re-presentation to same ED within 48 hours*
- *NEAT*
- *Collaborative meetings and documentation of discussions with all stakeholders*
- *Adverse outcomes monitoring (IIMS)*
- *Compliments and complaints*
- *ACE phone call record*

Please include analysis of your data to demonstrate that objectives were met and impact of the implementation of the ACE model.

A total of 71 patients presented to LBH ED from March 6 to July 31 2013 from the 4 RACFs involved in the ACE Program. 13 of those patients presented during the business hours of ACE and were seen in ED and discharged back to the RACF with an average LOS in ED of 3.3 hours.

Only 4 patients presented without phoning ACE prior to arrival during ACE business hours this was early in the implementation of the Program.

Patients who had to present to ED and were able to be discharged back to the RACF came for scans, investigations or treatment.

People who were admitted to hospital were requiring further treatment or patients who had arrived after hours, ready for discharge and waiting for transport first thing in the morning avoiding an overnight stay in ED.

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Admitted patients had a reduced number of occupied bed days by an average of 1.5 bed days per patient during the 5 month period compared with the same period in 2012.

There was an improvement in Health related outcomes for those patients who were able to be returned to the RACFs or transferred to the ward in a timely manner and avoid an extended LOS in ED.

DATA ANALYSIS

Samples: Two 5 month periods (Mar-Jul 2012 & Mar-Jul 2013). The 2013 sample is divided into 2 sub-groups: ACE patients and non-ACE patients (seen by ACE but admitted).

ED LENGTH OF STAY

Grp	N=	ED LOS (mean hrs)	SD (hrs)
ACE (2013)	34	6.7	5.4
Non-ACE (2013)	37	11.8	5.4
Comparison (2012)	87	10.2	6.6

One way analysis of variance (ANOVA) indicates that this difference is statistically significant (F=6.5; P=0.002). A direct 2012 vs 2013 comparison shows a difference in means (2013 mean ED LOS=9.4 hrs vs 2012 mean ED LOS=10.2 hours, but this difference is not significant [F=0.7; P=0.39].

NEAT

ED LOS was also explored among a smaller ACE subset in 2013. This was the group of patients who presented within our hours of operation, and who went on to be returned to the RACF. This comparison indicated that the 13 patients who presented within hours and were returned had a mean **ED LOS of 3.3 hours** (SD 2.9). The combined remainder of the 2013 group had a mean ED LOS of 10.8 hours (SD 5.6). This difference was significant (ANOVA: F=10.2; P=0.002).

NEAT

Grp	N=	Met NEAT (n=)	Didn't meet (n=)	% Met NEAT
ACE (2013)	34	14	20	41
Non-ACE (2013)	37	3	34	8
Comparison (2012)	87	8	79	9

Chi-square analysis indicates that this difference is statistically significant (x^2=20.9; P<0.0001). A direct 2012 vs 2013 comparison also shows a significant difference (% met NEAT in 2013=24% vs % met NEAT in 2012=9%) [x^2=6.4; P=0.01].

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OCCUPIED BED DAYS

Grp	N=	Bed days (mean)	SD
ACE (2013)	34	0.3	0.2
Non-ACE (2013)	37	4.0	3.2
Comparison (2012)	87	3.6	4.9

ANOVA indicates that this difference is statistically significant (F=6.5; P=0.002). A direct 2012 vs 2013 comparison also shows a significant difference (mean 2.1 days in 2013 vs mean 3.6 days in 2012) [ANOVA: F=4.7; P=0.031]

- The 2012/13 comparison indicates that a mean of 1.5 bed days per patient were saved in the 5 month period.
- 71 patients were seen in the 5 month period in 2013
- Extrapolating this outwards to 12 months and accounting for difference in numbers presenting in the previous year's (2012) five month period(n=87), allows us to project a number of patients dealt with over a 12 month period as n=189
- 189 x 1.5=283.5 bed days saved for a projected 12 month period (4 NHs only)
- 283.5 x $400 (approx. cost per bed day as provided by Pam Mitchell, Clinical Governance) = **$113,400**
- If a greater target were sought for an ongoing ACE presence (i.e. more NHs in your catchment), you could estimate further upwards and outwards from there

REPRESENTATIONS

There were no representations within 48 hours

COLLABORATION OF STAKEHOLDERS

Meetings were held with individual stakeholders at the beginning of the project to discuss how they could be involved with the program. Community Services such as Palliative Care, HITH, Stomal CNC, DBMS and the NSW Ambulance Service and inter hospital services stakeholders such as the Bed Manager, Hospital Transport and After Hours Nurse Managers. Minutes are available from these meetings. Follow up communication was by email or telephone contact.

Monthly Steering Committee meetings were held to assess and discuss the progress of the ACE Project which included Geriatricians, Director of Emergency Medicine, Psychogeriatric Nurse Practitioner, and AARCs, ASET representatives from the RACFs and Medicare Local and DON. Minutes are available from all of the meetings.

A dinner sponsored by Medicare Local was held where GPs and Residential Managers from the 4 RACFs were invited to be introduced to the ACE Program; Jacqueline Hewitt from John Hunter Hospital attended and explained the benefits of using the project and how it was implemented in her Local Area Health Service. This gave opportunity for discussion and fears to be allayed regarding concerns from the GPs and Residential Managers as to what their role would be and concerns for the patients. A transcript of the evening is available.

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In June a meeting with stakeholders GPs, Residential Managers and Steering Committee Members, to discuss the progress and sustainability of the ACE Program was held. The feedback from everyone involved was very positive, and unanimously agreed they would like to see the project continue and expand. It also gave the opportunity for other suggestions to be made from the GPs to access LBH for short procedures which reduced LOS and ED avoidance for elderly patients. Minutes from this meeting are available.

COMPLIMENTS and COMPLAINTS

There was a lot of positive feedback about the ACE program from the staff who attended the simulator education days on the pre and post surveys. Positive feedback from the Residential Managers who said staff and families were happy with the care their relatives received and thankful they had someone advocating for their loved one in the ED.

GPs said that there had been improvement in the quality of information given by RACF staff when being contacted about patients and they enjoyed the increased communication from the hospital and being involved in the patients care.

ED Medical Staff have found the access to more accurate information regarding the reason for the patient's presentation and Goals of Care to be useful when treating patients and saves them time searching.

The above comments can be supported by reading the minutes from the stakeholder meeting on June 2013.

Below is an email we received from the Clinical Nurse Educator at Caroona RACF expressing her support of the project:

Hi Isla/Kath,

I am sorry but I will be unable to attend the meeting on Wednesday due to an unexpected trip to Sydney.

Please accept my congratulations for a successful programme and know that Uniting Care Caroona have benefited from this experience and are keen to keep it going into the future.

From all reports to me if an after business hours service could be established this would further improve your project goals for the health service.

Please pass on my thoughts to any you think warranted.

Kind Regards

Annette

Annette Barry

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We have not received any complaints.

6.Discussion

Was the implementation of ACE successful, why or why not? What were the lessons learnt during this implementation? What impact has this model had on management patients from Residential Aged Care Facilities? What would you do differently next time and why? What strategies did you put in place to ensure sustainability of ACE?

To date, the ACE program has been successful in preventing three residents from being transferred to the ED and able to organise treatment back at the facility. When looking at the data both pre and post evaluation, it has shown that GPs/ RACFs in the 2480 area do not regularly send their residents with problems that could have been managed in the facility to ED. The patients who did present to ED required diagnostic assessments such as X-Rays or CTs to rule out conditions and assist with their treatment. This meant that ACE did not greatly affect the issue of hospital avoidance, but influenced their ED LOS.

The implementation of ACE was successful in many ways. Before the implementation of ACE, there was a large gap between the RACFs in the area and Lismore Base Hospital. After the commencement of ACE, RACF staff often gave positive feedback regarding having ACE as a single point of contact. They stated they felt that things would be followed up, and both staff and families liked the fact that ACE would be there as an advocate if the resident had to be transferred to ED.

The ACE project was successful in reducing the length of stay in ED for patients not for admission. When ACE were called by RACF staff to notify them of a residents transfer to ED, they would talk to the medical staff and have a plan organised and people informed before the patient arrived. This meant that when the patient arrived, treatment would be commenced and results would be at hand by the time an ED doctor was available to see them. This made a significant difference on busy days in ED when patients would often be waiting for long periods before investigations and treatment commenced. ACE would also be involved in patients care whilst in the ED if the nurses allocated were busy with other patients, as well as liaising with the treating doctor to help facilitate their progress through the ED.

In the planning stage of the ACE project, it was identified by the GPs and RACFs that the documentation received regarding patients discharged from the ED was often lacking. RACF staff frequently stated that they received residents home after a stay in ED with no paper work or communication regarding what had happened during their stay. This was also a common theme amongst GPs looking after residents in RACFs. They felt that they did not receive adequate information regarding the residents stay in the ED. If an ED doctor writes a discharge referral, it automatically electronically gets sent to the patients GP informing them of their stay, treatment and plan but if it is not completed they do not receive any information. Since the implementation of the ACE project, every resident that ACE had contact with had a discharge referral completed. On the occasions where the ED doctor did not complete one, ACE would attend to it. When residents came to ED and left outside ACE hours, ACE would call the RACFs on their next working day and check that they had received adequate information including a discharge summary and would fax it to them if they had not. When residents did not require admission to hospital and were able to return home, ACE would call and discuss the discharge plans with the RACF staff. We would also discuss any issues that may have prevented it or made it difficult for them to receive the resident home and tried to resolve these issues, for example, ACE would organise medication charts to be filled in for any new discharge medications that the resident may need before they would be seen by their GP. When residents who ACE were involved with did require admission, ACE notified the Acute to Aged Related Care (AARCs) Nurse as well as clearly documenting the devised plan of care so that discharge planning could commence on admission.

Another aspect that made the ACE project a success was having a link between the hospital, RACFs and the community. There were occasions where ACE was able to enquire and provide details regarding issues between

the RACFs and community. For example, ACE organised accreditation for an RN providing dialysis in one of the outlying facilities not involved in the program that prevented the need for that resident to come to the hospital.

ACE also paved the way for Hospital in the Home (HITH) to be able to go to some of the facilities that were reluctant to take residents back with peripherally inserted central catheter (PICC) lines. Another example of this link was demonstrated by ACE providing information to the GPs about how they could organise short day procedures for residents in the hospital for things such as iron infusions, which would avoid transfer through ED.

Ward staff in LBH are becoming increasingly aware of the project and the ACE role is expanding to increase awareness of early discharge planning for residents from RACFs, for example, outlining the need for the organisation of discharge medications, and appropriate discharge communication.

The lessons that we have learnt throughout the implementation of the ACE project have included acknowledging that RACFs require more support, and that improved communication is essential. Shortly after the commencement of ACE when the outcome was noted by RACF staff, a common theme that kept getting relayed back to ACE was that they would really appreciate support out of business hours as this is when they need it most. The ACE CNC hours for intake calls were 0900-1630hr Monday-Friday. Up to date there have been 79 patients included in ACE -2 did not present, so 77 transfers to ED in total. Out of the 77 patients, 21 of the patients that presented did so on weekends. Therefore 28% of patients that came from the four RACFs did not benefit from any ACE involvement.

During the planning and implementation of the project, it has been obvious that there is a large gap between the RACFs and the hospital. There has been very little communication in the past, and limited understanding of each others role, expectations and limitations. During the implementation ACE has tried to address this issue by relationship building and providing education to both sides regarding each others workplace differences and requirements. We have learnt that communication between the RACFs, GPs, community and hospital is a necessity to provide insight into each others role and continuity of care for patients. The more that we work together and try to bridge that gap, the better off we are as health professionals and care providers.

We believe that the ACE project has had a positive impact on the management of patients from RACFs by improving the skill base of the RACF, decreasing the patients length of stay (LOS) in ED, and improving the exchange of information between the hospital, RACFs and GPs. ACE helped improve the skill base of the staff at the RACFs by developing and presenting educations sessions that were identified by staff as an area they needed education/ refreshing on. ACE also organised Simulation Training and were able to offer it for free to all RACFs included in the project as funding was provided by Medicare Local. The Simulation training was invaluable as it allowed open discussion and gave ACE a better understanding of the policies and procedures of the individual RACFs and how improvements could be made to support the staff. It also gave ACE the opportunity to explain the benefits of referring to the manual and discuss options on how to better manage common scenarios, and the usage of management plans for chronic conditions.

By decreasing the patients length of stay in ED, patients had investigations and results in a timelier manner and helped facilitate their progress through the ED. This meant that patients were less likely to be susceptible to problems such as dehydration, delirium, pressure sores, and exposure to illness and were able to go back to an environment that was familiar to them.

By improving the communication and documentation between the hospital and RACF, it provided better management of the patients, both in ED and on return to the RACF. When the handing over of information was sufficient, there appeared to be less confusion, better understanding and the flow of patient care improved.

There are not many things we would do differently but with the benefit of hindsight and having built relationships with the RACF staff, they are now more aware what education and skills they want to improve to increase their confidence in using the manual. It was very time consuming chasing commitment for education not because of

lack of interest but conflicting priorities at the facilities such as accreditation. A timetable for education 2 months in advance with a clear plan of what skills being offered may have prevented this.

Ongoing education to the staff in LBH and the RACFs regarding the significance of using the yellow envelopes (developed by at the Richmond Aged Care Services Meeting) when transferring someone to ED from a RACF, and from ED back to the RACF. The 'yellow envelope' is a method of using a familiar tool that encloses the relevant documentation that is needed when patients are transferred. For example, RACF put Advanced Care Directives, doctor's notes and a copy of current medication charts in the envelope and send it to ED. When the patient is discharged back to the facility, hospital staff put copies of their nursing and medical notes, medication charts, results from investigations attended and the patients discharge summary in the envelope to go back with the patient. ACE hopes to maintain staff awareness of the importance of communication, and encourage the use of the envelopes to prevent the previous state of a lack of documentation between the facilities occurring.

ACE has formed relationships with the four RACFs and the aged care networks both inside and outside of the hospital. They are gaining peoples trust, and have made changes that are obvious both in the ED and the RACFs. ACE is concerned that if no further funding becomes available for it to continue that the improved relationship between both areas will deteriorate when there is no further contact between them.

During the implementation of the project, ACE has been conscious of the need for sustainability of the project. We organised a meeting after hours with the GPs and RACFs involved and asked them if they had any suggestions on how to make the project sustainable. Although the GP feedback was that they were pleased with the project and keen to see it continues, there were no suggestions made how to make it sustainable.
ACE has also made contact with the Rural Health Network to promote the benefits of the project and its sustainability. The representative stated she will be presenting different projects to a committee to apply for ongoing funding and will let us know any progress.

ACE has also involved the clinical redesign team to assess the possibility of continuing funding into the future, who are looking at the data and taking it to the executives to discuss a business case with costs and benefits analyses, looking at what funding may be available and talking to the stakeholders. It is also being taken to a whole of hospital meeting to discuss options and assess how it could be continued or incorporated into existing services**.**

8. Conclusion

Where to from here? Please include plans for further evaluation of the impact of ACE on your Hospital and sustainability of this model in your Local Health District?

Residents from RACFs have high needs, are complex and often time consuming. The ACE team has time to gather all the relevant information from everyone, discuss management plans and understands how RACFs function and what their capabilities and limitations are. This has taken time to develop and is still a work in progress. The information ACE gathers and the liaising between the hospital and facilities allows treatment to flow smoothly and has been reflected in the data of decreased ED LOS.

It would be difficult to maintain this improvement without someone keeping these channels of communication open, and advocating for these patients from RACFs. The question is who would take over this role? 30% of the presentations to LBH ED are over 70 years of age. There are an increased number of elderly people independently living in the community due to the number of Aged Care Packages available, and this has resulted in an increased work load for the ASET team.

A whole of hospital analyses is taking place at LBH at the moment which is looking at services available within LBH and the patient journey. Options being investigated are for ACE to blend with other services such as ASET or

Aged Care Emergency model evaluation

AARCs with a whole of hospital focus which follows the patient journey from community to ED through to admission if necessary.

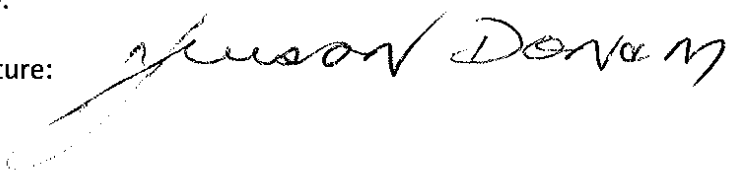
The plan for LBH to evaluate the impact of ACE in the future is to collect data from the 4 RACF in March of next year and compare this with the period that ACE has been implemented to look at increased numbers presenting, increases to ED LOS and occupied bed days. This would allow us to put forward a proposal for further funding perhaps to assist with the winter strategy.

There is still more work which can be done to bridge the gaps between the RACFs and Acute Care Sector of health. With the population living longer, this is an area which will expand into the future. ACE has developed very good working relationships with all the stakeholders and would like the opportunity to consolidate these relationships to prevent resistance with other projects being implemented in the future.

From the data collected the implementation of ACE will save the LHD a projected estimate of $113,400 this financial year just from the 4 RACFs involved. Given that there are 15 other RACFs in the immediate local network to which ACE could expand, there are significant savings to be made.

Chief Executive sign off on final report

Name:

Signature: 

Date:

Name: Narelle Gleeson – Director of Nursing and Midwifery, Lismore Base Hospital.

Signed 13/09/13